AMENDED IN SENATE MAY 6, 1999

SENATE BILL No. 931

Introduced by Senator Polanco

February 25, 1999

An act to ~~amend Section 650 of, and to~~ add Section 650.05 to~~,~~ the Business and Professions Code, relating to health care referrals.

LEGISLATIVE COUNSEL'S DIGEST

SB 931, as amended, Polanco. Health: unlawful referrals.

Existing law provides that the offer, delivery, receipt, or acceptance by any person licensed under the provisions regulating healing arts of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration as compensation or inducement for referring patients, clients, or customers to any person is unlawful, subject to various exceptions.

~~This bill would provide that those actions are unlawful only if knowing and willful.~~

~~The bill would specifically provide with respect to state and federal programs that the prohibition does not apply to certain investment interests, leases, contracts, referral services, warranties, discounts, compensation, remuneration, waivers of coinsurance and deductibles, increased coverage, or price reductions. The~~

This bill would ~~also~~ provide ~~for that purpose~~ that ''compensation or inducement'' does not include *a reduction in price a contract* health care ~~services provided or discounts offered by a professional to an enrollee of a health care service~~

~~plan~~ *provider offers to a health plan in accordance with the terms of a written agreement between the contract health care provider and the health plan for the sole purpose of furnishing to enrollees items or services covered by the health plan, a federal health care program, or a state health care program, or a reduction in price voluntarily provided by a health plan, as specified.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 650 of the Business and Professions Code is amended to read:~~

~~650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the knowing and willful offer, delivery, receipt, or acceptance by any person licensed under this division of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest or coownership in or with any person to whom these patients, clients or customers are referred is unlawful.~~

~~The knowing and willful payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payor.~~

~~(b) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to~~

~~Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility; provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.~~

~~(c) As used in this section:~~

~~(1) ''Federal health care program'' means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, other than the health insurance program under Chapter 89 (commencing with Section 8901) of Title 5 of the United States Code.~~

~~(2) ''State health care program'' means a state plan approved under Subchapter XIX of the Social Security Act, any program receiving funds under Subchapter V of the Social Security Act, or from an allotment to the state under those provisions, a program receiving funds under Subchapter XX of the Social Security Act or from an allotment to the state under that subchapter, or a state child health plan approved under Subchapter XXI of the Social Security Act or an entity licensed, as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).~~

~~(3) ''Health care facility'' means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Health Services under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.~~

~~(d) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding ten thousand dollars ($10,000), or by both such imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison.~~

~~SEC. 2.~~

SECTION 1. Section 650.05 is added to the Business and Professions Code, to read:

~~650.05. The prohibition of Section 650 do not apply to or restrict any of the following:~~

~~(a) Any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as all of the applicable standards are met within one of the two categories of entities described in paragraph (1) or (2):~~

~~(1) If, within the previous fiscal year or previous 12-month period, the entity possesses more than fifty million dollars ($50,000,000) in undepreciated net tangible assets, based on the net acquisition cost of purchasing those assets from an unrelated entity, related to the furnishing of items and services, and if all of the following five applicable standards are met:~~

~~(A) With respect to an investment interest that is an equity security, the equity security must be registered with the Securities and Exchange Commission under subsection (b) or (g) of Section 781 of Title 15 of the United States Code.~~

~~(B) The investment interest of an investor in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity shall be obtained on terms equally available to the public through trading on a registered national securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or on the National Association of Securities Dealers Automated Quotation System.~~

~~(C) The entity or any investor shall not market or furnish the entity's items or services (or those of another~~

~~entity as part of a cross-referral agreement) to passive investors differently than to noninvestors.~~

~~(D) The entity shall not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.~~

~~(E) The amount of payment to an investor in return for the investment interest shall be directly proportional to the amount of the capital investment of that investor.~~

~~(2) If the entity possesses investment interests that are held by either active or passive investors, it shall meet all of the following eight applicable standards:~~

~~(A) No more than 40 percent of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous 12-month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.~~

~~(B) The terms on which an investment interest is offered to a passive investor, if any, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity shall be no different from the terms offered to other passive investors.~~

~~(C) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity shall not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.~~

~~(D) There is no requirement that a passive investor, if any, make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.~~

~~(E) The entity or any investor shall not market or furnish the entity's items or services, or those of another~~

~~entity as part of a cross-referral agreement, to passive investors differently than to noninvestors.~~

~~(F) No more than 40 percent of the gross revenue of the entity in the previous fiscal year or previous 12-month period may come from referrals, items or services furnished, or business otherwise generated from investors.~~

~~(G) The entity shall not loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.~~

~~(H) The amount of payment to an investor in return for the investment interest shall be directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, of that investor.~~

~~(3) For purposes of this subdivision, the following terms apply:~~

~~(A) "Active investor" means an investor either who is responsible for the day-to-day management of the entity and is a bona fide general partner in a partnership under the Uniform Partnership Act or who agrees in writing to undertake liability for the actions of the entity's agents acting within the scope of their agency.~~

~~(B) "Investment interest" means a security issued by an entity, and may include the following classes of investments: shares in a corporation, interests or units of a partnership, bonds, debentures, notes, or other debt instruments.~~

~~(C) "Investor" means an individual or entity either who directly holds an investment interest in an entity, or who indirectly holds investment interest in an entity, including, but not limited to, having a family member hold an investment interest or holding a legal or beneficial interest in another entity, such as a trust or holding company, that holds the investment interest.~~

~~(D) "Passive investor" means an investor who is not an active investor, such as a limited partner in a partnership~~

~~under the Uniform Partnership Act, a shareholder in a corporation, or a holder of a debt security.~~

~~(b) As used in Section 650, "compensation or inducement" does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following five standards are met:~~

~~(1) The lease agreement is set out in writing and signed by the parties.~~

~~(2) The lease specifies the premises covered by the lease.~~

~~(3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of intervals, their precise length, and the exact rent for the intervals.~~

~~(4) The term of the lease is for not less than one year.~~

~~(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under a federal or a state health care program.~~

~~(6) For purposes of this subdivision, "fair market value" means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party, either the prospective lessee or lessor, would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under a federal or a state health care program.~~

~~(c) As used in Section 650, "compensation or inducement" does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following five standards are met:~~

~~(1) The lease agreement is set out in writing and signed by the parties.~~

~~(2) The lease specifies the equipment covered by the lease.~~

~~(3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of intervals, their precise length, and the exact rent for the interval.~~

~~(4) The term of the lease is for not less than one year.~~

~~(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under a federal or a state health care program.~~

~~(6) For purposes of this subdivision, ''fair market value'' means the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party, either the prospective lessee or lessor, would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under a federal or a state health care program.~~

~~(d) As used in Section 650, ''compensation or inducement'' does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following six standards are met:~~

~~(1) The agency agreement is set out in writing and signed by the parties.~~

~~(2) The agency agreement specifies the services to be provided by the agent.~~

~~(3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of intervals, their precise length, and the exact charge for the intervals.~~

(4) The term of the agreement is for not less than one year.

(5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under a federal or a state health care program.

(6) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(7) For purposes of this subdivision, an ''agent of a principal'' is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.

(e) As used in Section 650, ''compensation or inducement'' does not include any payment made to a practitioner by another practitioner where the former practitioner is selling his or her practice to the latter practitioner, as long as both of the following two standards are met:

(1) The period from the date of the first agreement pertaining to the sale to the completion of the sale is not more than one year.

(2) The practitioner who is selling his or her practice will not be in a professional position to make referrals to, or otherwise generate business for, the purchasing practitioner for which payment may be made in whole or in part under a federal or a state health care program after one year from the date of the first agreement pertaining to the sale.

(f) As used in Section 650, ''compensation or inducement'' does not include any payment or exchange of anything of value between an individual or entity who participates in a referral service and another entity serving as a referral service as long as all of the following four standards are met:

~~(1) The referral service does not exclude as a participant in the referral service any individual or entity who meets the qualifications for participation.~~

~~(2) Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by the participants for the referral service for which payment may be made in whole or in part under a federal or a state health care program.~~

~~(3) The referral service imposes no requirements on the manner in which the participant provides services to a referred person, except that the referral service may require that the participant charge the person referred at the same rate as it charges other persons not referred by the referral service, or that these services be furnished free of charge or at reduced charge.~~

~~(4) The referral service makes the following five disclosures to each person seeking a referral, with each disclosure maintained by the referral service in a written record certifying the disclosure and signed by either the person seeking a referral or by the individual making the disclosure on behalf of the referral service:~~

~~(A) The manner in which it selects the group of participants in the referral service to which it could make a referral.~~

~~(B) Whether the participant has paid a fee to the referral service.~~

~~(C) The manner in which it selects a particular participant from this group for that person.~~

~~(D) The nature of the relationship between the referral service and the group of participants to whom it could make the referral.~~

~~(E) The nature of any restrictions that would exclude an individual or entity from continuing as a participant.~~

~~(g) As used in Section 650, ''compensation or inducement'' does not include any payment or exchange of anything of value under a warranty provided by a manufacturer or supplier of an item to the buyer, such as~~

~~a health care provider or beneficiary, of the item, as long as the buyer complies with all of the following standards in paragraph (1) and the manufacturer or supplier complies with all of the following standards in paragraph (2).~~

~~(1) (A) The buyer shall fully and accurately report any price reduction of the item, including a free item, that was obtained as part of the warranty, in the applicable cost reporting mechanism or claim for payment filed with the federal agency or a state agency.~~

~~(B) The buyer shall provide, upon request by a state agency, information provided by the manufacturer or supplier as specified in subparagraph (B) of paragraph (2).~~

~~(2) (A) The manufacturer or supplier shall comply with either of the following two standards:~~

~~(i) The manufacturer or supplier shall fully and accurately report the price reduction of the item, including a free item, which was obtained as part of the warranty, on the invoice or statement submitted to the buyer.~~

~~(ii) Where the amount of the price reduction is not known at the time of sale, the manufacturer or supplier shall fully and accurately report the existence of a warranty on the invoice or statement, inform the buyer of its obligations under subparagraphs (A) and (B) of paragraph (1), and, when the price reduction becomes known, provide the buyer with documentation of the calculation of the price reduction resulting from the warranty.~~

~~(B) The manufacturer or supplier shall not pay any remuneration to any individual, other than a beneficiary, or entity for any medical, surgical, or hospital expense incurred by a beneficiary other than for the cost of the item itself.~~

~~(3) For purposes of this subdivision, ‘‘warranty’’ means a manufacturer’s or supplier’s agreement to replace another manufacturer’s or supplier’s defective item, which is covered by an agreement made in accordance~~

~~with this statutory provision, on terms equal to the agreement that it replaces.~~

~~(h) As used in Section 650, ''compensation or inducement'' does not include a discount, as defined in paragraph (3), on a good or service received by a buyer that submits a claim or request for payment for the good or service for which payment may be made in whole or in part under a federal or a state health care program from a seller as long as the buyer complies with the applicable standards of paragraph (1), and the seller complies with the applicable standards of paragraph (2).~~

~~(1) With respect to the following three categories of buyers, the buyer shall comply with all of the applicable standards within each category:~~

~~(A) If the buyer is an entity that reports its costs on a cost report required by a federal agency or a state agency, it shall comply with all of the following four standards:~~

~~(i) The discount shall be earned based on purchases of that same good or service bought within a single fiscal year of the buyer.~~

~~(ii) The buyer shall claim the benefit of the discount in the fiscal year in which the discount is earned or the following year.~~

~~(iii) The buyer shall fully and accurately report the discount in the applicable cost report.~~

~~(iv) The buyer shall provide, upon request by a federal agency or a state agency, information provided by the seller as specified in subparagraph (B) of paragraph (2).~~

~~(B) If the buyer is an entity that is a health maintenance organization or competitive medical plan acting in accordance with a risk contract under a federal health care program or a state health care program, it need not report the discount except as otherwise may be required under the risk contract.~~

~~(C) If the buyer is not an entity described in subparagraph (A) or (B), it shall comply with all of the following three standards:~~

~~(i) The discount shall be made at the time of the original sale of the good or service.~~

(ii) Where an item or service is separately claimed for payment with the federal or a state agency, the buyer shall fully and accurately report the discount on that item or service.

(iii) The buyer shall provide, upon request of the federal agency or state agency, information provided by the seller as specified in clause (i) of subparagraph (B) of paragraph (2).

(2) With respect to either of the following two categories of buyers, the seller shall comply with all of the applicable standards within each category:

(A) If the buyer is an entity described in subparagraph (B) of paragraph (1), the seller need not report the discount, to the buyer for purposes of this provision.

(B) If the buyer is any other individual or entity, the seller shall comply with either of the following two standards:

(i) Where a discount is required to be reported to a federal agency or a state agency under paragraph (1), the seller shall fully and accurately report the discount on the invoice or statement submitted to the buyer, and inform the buyer of its obligations to report the discount.

(ii) Where the value of the discount is not known at the time of sale, the seller shall fully and accurately report the existence of a discount program on the invoice or statement submitted to the buyer, inform the buyer of its obligations under paragraph (1) and, when the value of the discount becomes known, provide the buyer with documentation of the calculation of the discount identifying the specific goods or services purchased to which the discount will be applied.

(3) For purposes of this paragraph, ‘‘discount’’ means a reduction in the amount a seller charges a buyer, who buys either directly or through a wholesaler or a group purchasing organization, for a good or service based on an arms-length transaction. The term ‘‘discount’’ may include a rebate check, credit, or coupon directly redeemable from the seller only to the extent that the reductions in price are attributable to the original good

~~or service that was purchased or furnished. ''Discount'' does not include any of the following:~~

~~(A) Cash payment.~~

~~(B) Furnishing one good or service without charge or at a reduced charge in exchange for any agreement to buy a different good or service.~~

~~(C) A reduction in price applicable to one payor but not to Medicare or a state health care program.~~

~~(D) A routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary.~~

~~(E) Warranties.~~

~~(F) Services provided in accordance with a personal or management services contract.~~

~~(G) Other remuneration in cash or in kind not explicitly described in this paragraph.~~

~~(i) As used in Section 650, ''compensation or inducement'' does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare or a state health care program. For purposes of this subdivision, the term employee has the same meaning as it does for purposes of paragraph (2) of subsection (d) of Section 3121 of Title 26 of the United States Code.~~

~~(j) As used in Section 650, ''remuneration'' does not include any payment by a vendor of goods or services to a group purchasing organization, as part of an agreement to furnish those goods or services to an individual or entity as long as both of the following two standards are met:~~

~~(1) The group purchasing organization shall have a written agreement with each individual or entity, for which items or services are furnished, that provides for either of the following:~~

~~(A) The agreement states that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the group purchasing organization of 3 percent or less of the purchase price of the goods or services provided by that vendor.~~

(B) In the event the fee paid to the group purchasing organization is not fixed at 3 percent or less of the purchase price of the goods or services, the agreement specifies the amount, or if not known, the maximum amount, the group purchasing organization will be paid by each vendor, where that amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the group purchasing organization.

(2) Where the entity that receives the goods or service from the vendor is a health care provider of services, the group purchasing organization shall disclose in writing to the entity at least annually, and to the federal or state agency upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

(3) For purposes of this subdivision, ''group purchasing organization'' means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under a federal or a state health care program, and who are neither wholly owned by the group purchasing organization nor subsidiaries of a parent corporation that wholly owns the group purchasing organization either directly or through another wholly owned entity.

(k) As used in Section 650, ''compensation or inducement'' does not include any reduction or waiver of a Medicare or a state health care program beneficiary's obligation to pay coinsurance or deductible amounts as long as all of the standards are met within either of the following two categories of health care providers:

(1) If the coinsurance or deductible amounts are owed to a hospital for inpatient hospital services for which a federal or state health care program pays under the prospective payment system, the hospital shall comply with all of the following three standards:

(A) The hospital shall not later claim the amount reduced or waived as a bad debt for payment purposes

~~under a federal or state health care program or otherwise shift the burden of the reduction or waiver onto a federal health care program, a state health care program, other payers, or individuals.~~

~~(B) The hospital shall offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic-related group for which the claim for reimbursement is filed.~~

~~(C) The hospital's offer to reduce or waive the coinsurance or deductible amounts shall not be made as part of a price reduction agreement between a hospital and a third-party payer, including a health plan as defined in paragraph (2) of subdivision (l), unless the agreement is part of a contract for the furnishing of items or services to a beneficiary of a federal health care program supplemental policy issued under the terms of paragraph (1) of subsection (t) of Section 1882 of the Social Security Act (42 U.S.C. Sec. 1395ss).~~

~~(2) If the coinsurance or deductible amounts are owed by an individual who qualifies for subsidized services under a provision of the Public Health Services Act (42 U.S.C. Sec. 201 et seq.) or under Title V (42 U.S.C. Sec. 701 et seq.) or Title XIX (42 U.S.C. Sec. 1396 et seq.) of the Social Security Act to a federally qualified health care center or other health care facility under those acts, the health care center or facility may reduce or waive the coinsurance or deductible amounts for items or services for which payment may be made in whole or in part under a federal health care program or a state health care program.~~

~~(*l*) (1) As used in Section 650 "compensation or inducement" does not include the additional coverage of any item or service offered by a health plan to an enrollee or the reduction of some or all of the enrollee's obligation to pay the health plan or a contract health care provider for cost-sharing amounts, such as coinsurance, deductible, or copayment amounts, or for premium amounts attributable to items or services covered by the health plan, a federal health care program, or a state health care~~

~~program, as long as the health plan complies with all of the standards within one of the following two categories of health plans:~~

~~(A) If the health plan is a risk-based health maintenance organization, competitive medical plan, prepaid health plan, or other health plan under contract with the federal Health Care Finance Authority or a state health care program and operating in accordance with subsection (g) of Section 1876 of the Social Security Act (42 U.S.C. Sec. 1395(g)) or subsection (m) of Section 1903 of the Social Security Act (42 U.S.C. Sec. 1396b(m)), under a federal statutory demonstration authority, or under other federal statutory or regulatory authority, it shall offer the same increased coverage or reduced cost-sharing or premium amounts to all federal health care program or state health care program enrollees covered by the contract unless otherwise approved by the federal Health Care Finance Authority or by a state health care program.~~

~~(B) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment plan, prepaid health plan, or other health plan that has executed a contract or agreement with the federal Health Care Finance Authority or with a state health care program to receive payment for enrollees on a reasonable cost or similar basis, it shall comply with both of the following two standards:~~

~~(i) The health plan shall offer the same increased coverage or reduced cost-sharing or premium amounts to all federal health care program or state health care program enrollees covered by the contract or agreement unless otherwise approved by the federal Health Care Finance Authority or by a state health care program.~~

~~(ii) The health plan shall not claim the costs of the increased coverage or the reduced cost-sharing or premium amounts as a bad debt for payment purposes under a federal health care program or a state health care program or otherwise shift the burden of the increased coverage or reduced cost-sharing or premium amounts to the extent that increased payments are claimed from a~~

federal health care program or a state health care program.

(2) For purposes of paragraph (1):

(A) ''Contract health care provider'' means an individual or entity under contract with a health plan to furnish items or services to enrollees who are covered by the health plan, a federal health care program, or a state health care program.

(B) ''Enrollee'' means an individual who has entered into a contractual relationship with a health plan, or on whose behalf an employer, or other private or governmental entity has entered into such a relationship, under which the individual is entitled to receive specified health care items and services, or insurance coverage for such items and services, in return for payment of a premium or a fee.

(C) ''Health plan'' means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of those items and services, in exchange for a premium or a fee, where that entity:

(i) Operates in accordance with a contract, agreement or statutory demonstration authority approved by the federal Health Care Finance Authority or a state health care program.

(ii) Charges a premium and its premium structure is regulated under a state insurance statute or a state enabling statute governing health maintenance organizations or preferred provider organizations.

(iii) Is an employer, if the enrollees of the plan are current or retired employees, or is a union welfare fund, if the enrollees of the plan are union members.

(iv) Is licensed in the state, is under contract with an employer, union welfare fund, or a company furnishing health insurance coverage as described in clauses (ii) and (iii), and is paid a fee for the administration of the plan that reflects the fair market value of those services.

(m) (1)

650.05. (a) As used in Section 650, ‘‘compensation or inducement’’ does not include a reduction in price a contract health care provider offers to a health plan in accordance with the terms of a written agreement between the contract health care provider and the health plan for the sole purpose of furnishing to enrollees items or services that are covered by the health plan, a federal health care program, or a state health care program, *or a reduction in price voluntarily provided by the health plan*, as long as both the health plan and contract health care provider comply with all of the applicable standards within one of the following four categories of health plans:

~~(A)~~

(1) If the health plan is a risk-based health maintenance organization, competitive medical plan, or prepaid health plan under contract with the federal Health Care Finance Authority or a state agency and operating in accordance with subsection (g) of Section 1876 of the Social Security Act (42 U.S.C. Sec. 1395(g)) or subsection (m) of Section 1903 of the Social Security Act (42 U.S.C. Sec. 1396b(m)), under a federal statutory demonstration authority, or under other federal statutory or regulatory authority, the contract health care provider shall not claim payment in any form from the federal health care program or the state agency for items or services furnished in accordance with the agreement except as approved by the federal health care finance authority or the state health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a state health care program.

~~(B)~~

(2) If the health plan is a health maintenance organization, competitive medical plan, health care prepayment plan, prepaid health plan, or other health plan that has executed a contract or agreement with federal health care finance authority or the state health care program to receive payment for enrollees on a reasonable cost or similar basis, the health plan and

contract health care provider shall comply with all of the following four standards:

~~(i)~~

(A) The term of the agreement between the health plan and the contract health care provider shall be for not less than one year.

~~(ii)~~

(B) The agreement between the health plan and the contract health care provider shall specify in advance the covered items and services to be furnished to enrollees, and the methodology for computing the payment to the contract health care provider.

~~(iii)~~

(C) The health plan shall fully and accurately report, on the applicable cost report or other claim form filed with the federal health care program or the state health care program, the amount it has paid the contract health care provider under the agreement for the covered items and services furnished to enrollees.

~~(iv)~~

(D) The contract health care provider shall not claim payment in any form from the federal health care program or the state health care program for items or services furnished in accordance with the agreement except as approved by federal health care finance authority or the state health care program, or otherwise shift the burden of the agreement to the extent that increased payments are claimed from a federal health care program or a state health care program.

~~(C)~~

(3) If the health plan is not described in ~~subparagraphs (A) or (B)~~ *paragraph (1) or (2)* and the contract health care provider is not paid on an at-risk, capitated basis, both the health plan and contract health care provider shall comply with all of the following six standards:

~~(i)~~

(A) The term of the agreement between the health plan and the contract health care provider shall be for not less than one year.

~~(ii)~~

(B) The agreement between the health plan and the contract health care provider shall specify in advance the covered items and services to be furnished to enrollees, which party is to file claims or requests for payment with the federal health care program or the state health care program for those items and services, and the schedule of fees the contract health care provider will charge for furnishing such items and services to enrollees.

~~(iii)~~

(C) The fee schedule contained in the agreement between the health plan, and the contract health care provider shall remain in effect throughout the term of the agreement, unless a fee increase results directly from a payment update authorized by the federal health care program or the state health care program.

~~(iv)~~

(D) The party submitting claims or requests for payment from the federal health care program or the state health care program for items and services furnished in accordance with the agreement shall not claim or request payment for amounts in excess of the fee schedule.

~~(v)~~

(E) The contract health care provider and the health plan shall fully and accurately report on any cost report filed with a federal health care program or a state health care program the fee schedule amounts charged in accordance with the agreement and, upon request, will report to a federal health care program or a state health care program the terms of the agreement and the amounts paid in accordance with the agreement.

~~(vi)~~

(F) The party to the agreement who does not have the responsibility under the agreement for filing claims or requests for payment shall not claim or request payment in any form from a federal health care program or the state health care program for items or services furnished in accordance with the agreement, or otherwise shift the burden of such an agreement to the extent that increased

payments are claimed from a federal health care program or a state health care program.

~~(D)~~

(4) If the health plan is not described in ~~subparagraphs (A) or (B) of paragraph (1)~~ *paragraph (1) or (2) of subdivision (a)*, and the contract health care provider is paid on an at-risk, capitated basis, both the health plan and contract health care provider shall comply with all of the following five standards:

~~(i)~~

(A) The term of the agreement between the health plan and the contract health provider shall be for not less than one year.

~~(ii)~~

(B) The agreement between the health plan and the contract health provider shall specify in advance the covered items and services to be furnished to enrollees and the total amount per enrollee, which may be expressed in a per month or other time period basis, the contract health care provider will be paid by the health plan for furnishing such items and services to enrollees and shall set forth any copayments, if any, to be paid by enrollees to the contract health care provider for covered services.

~~(iii)~~

(C) The payment amount contained in the agreement between the health care plan and the contract health care provider shall remain in effect throughout the term of the agreement.

~~(iv)~~

(D) The contract health care provider and the health plan shall fully and accurately report to the federal health care program and state health care program upon request, the terms of the agreement and the amounts paid in accordance with the agreement.

~~(v)~~

(E) The contract health care provider shall not claim or request payment in any form from the federal health care program, a state health care program or an enrollee, other than copayment amounts described in ~~clause (ii)~~

subparagraph (B) and the health plan shall not pay the contract care provider in excess of the amounts described in ~~clause (ii)~~ *subparagraph (B)* for items and services covered by the agreement.

~~(2) For purposes of this subdivision, the terms contract health care provider, enrollee, and health plan have the same meaning as in subdivision (*l*).~~

(b) For purposes of this section, the following definitions shall apply:

(1) "Contract health care provider" means an individual or entity under contract with a health plan to furnish items or services to enrollees who are covered by the health plan, a federal health care program, or a state health care program.

(2) "Enrollee" means an individual who has entered into a contractual relationship with a health plan, or on whose behalf an employer, or other private or governmental entity has entered into such a relationship, under which the individual is entitled to receive specified health care items and services, or insurance coverage for such items and services, in return for payment of a premium or a fee.

(3) "Health plan" means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of those items and services, in exchange for a premium or a fee, where that entity:

(A) Operates in accordance with a contract, agreement or statutory demonstration authority approved by the federal Health Care Finance Authority or a state health care program.

(B) Charges a premium and its premium structure is regulated under a state insurance statute or a state enabling statute governing health maintenance organizations or preferred provider organizations.

(C) Is an employer, if the enrollees of the plan are current or retired employees, or is a union welfare fund, if the enrollees of the plan are union members.

(D) Is licensed in the state, is under contract with an employer, union welfare fund, or a company furnishing health insurance coverage as described in subparagraphs (B) and (C), and is paid a fee for the administration of the plan that reflects the fair market value of those services.

~~(n) As used in Section 650, ''compensation or inducement'' does not include health care services provided or discounts offered by a professional to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).~~

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